V. Questions

This RFI is issued to obtain information only and is not intended to directly result in contracts with any respondent

INSTRUCTIONS

Only organizations licensed to accept risk in Tennessee or another state should respond to this RFI. Please provide clear and concise responses to the questions in Section V. **Responses shall be a maximum of 35 pages (including any attachments).**

Responses that include "Proprietary" information should be clearly marked; the State will not release proprietary information, but cannot protect information from distribution that is subject to the Freedom of Information Act.

ADDITIONAL INFORMATION

The State will have an information session for potential respondents. Details about this session (date, time, and place) will be posted on the TennCare website (www.tennessee.gov/tenncare/).

Additional information related to TennCare can also be found on the TennCare website.

DUE DATE

Responses to the questions on the following pages must be received by **10:00 a.m. Central Standard Time, Monday, December 5, 2005** to be considered by the State. Please include two hard copies and an electronic copy (MS Word) on CD or diskette. Responses should be sent to:

Alma Chilton, Contract Coordinator
Bureau of TennCare
310 Great Circle Rd
Nashville, TN 37243
(615) 507-6384
alma.chilton@state.tn.us

CORPORATE BACKGROUND AND EXPERIENCE

Please provide the information requested below about your organization.

1. **Corporate Information**

   John Deere Health Care, Inc.
   1300 River Drive, Suite 200
   Moline IL 61265
   309-765-1200

2. **If a subsidiary or affiliate of a parent organization, corporate information of parent organization**

   Deere and Company
   One John Deere Place
   Moline, IL 61265
   (309)765-8000

3. **State of incorporation or where otherwise organized to do business**

   John Deere Health is incorporated in the State of Illinois. JDH is currently doing business in Iowa, Illinois, Tennessee, and Virginia.

4. **States where currently licensed to accept risk and a description of each license.**

   Illinois - licensed as John Deere Health Plan to sell group HMO products, and as John Deere Health Insurance to sell group health products.
   Iowa - licensed as John Deere Health Plan to sell group HMO products, and as John Deere Health Insurance to sell group health products.
   Tennessee - licensed as John Deere Health Plan to sell group HMO products.
   Virginia - licensed as John Deere Health Plan to sell group HMO products.

5. **Contact Information**

   Tina M. Brill, Regional Manager, Government Programs
   408 Cedar Bluff Road, Suite 400
   Knoxville, TN 37923
   865-769-1559
   BrillTinaM@JohnDeere.com

6. **Program Experience – General**

   Given TennCare's history with small, inexperienced plans becoming insolvent, the State is interested in contracting with MCOs that have

substantial experience with capitation, particularly for the Medicaid population. Tennessee also intends to require that all MCOs be NCQA accredited or receive NCQA-accreditation for the Medicaid product within a specified time period after contract award.

a) Do you have at least three years Medicaid experience under capitation? If yes, please identify the states and contract periods. If no, do you have at least three years of experience under capitation in another market?

Yes, John Deere Health has participated in the TennCare program since January 1, 1994 and was fully capitated until July 1, 2001 when it entered into a shared risk and then self-funded stabilization period. JDH has participated in a fully capitated Medicaid product in Iowa from 1986-2004. We have operated a SCHIP program in Iowa since 2000 that is fully insured. JDH has also operated fully insured commercial products in Iowa and Illinois since 1985, Tennessee since 1986 and Virginia since 1995 and a fully insured Medicare product in Tennessee since 1997.

b) Are you currently accredited by NCQA for your Medicaid product line? If no, are your or any other plans operated by your parent or affiliate NCQA accredited? Which product lines? Would you be willing to become NCQA accredited within a reasonable period of time after contract award? Do you have experience with HEDIS and CAHPS? Please explain.

John Deere Health Care, Inc. is NCQA accredited for our commercial and Medicare product lines. In 1999, JDH received a Commendable rating by NCQA. In 2000, JDH received and Excellent rating from NCQA and has maintained that rating. JDH is sitting for TennCare accreditation in March 2006.

c) Do you currently contract with any State to provide Medicaid services? If yes, proceed to question 7. If no, proceed to question 10.

Yes, John Deere Health contracts with the State of Tennessee for the TennCare program and contracts with the state of Iowa for their SCHIP program called hawk-i.

7. Medicaid Program Experience – Services

Using the list below, please provide a chart that indicates for each of the states where you currently contract: 1) whether you provide the service; and 2) whether you provide the service directly or through a subcontract arrangement.

As an MCO, John Deere Health does not directly provide medical services to members, but we have noted where we directly provide or contract for

services, contract with a subcontractor, or do not provide the service under our contract with the State of Tennessee.

a. Physical Health Benefits – Directly contracted
b. Dental Benefits – Do not provide
c. Vision Benefits – Provide through subcontractor
d. Non-Emergency Transportation - Provide through subcontractor
e. Behavioral Health Benefits – Do not provide
f. Pharmacy Benefits – Do not provide
g. Long-Term Care Benefits (nursing facility and home and community based waiver services) – Do not provide
h. Home Health – Directly contracted
i. Claims Processing and Adjudication – Directly provide
j. Quality Assurance – Directly provide
k. Utilization Management – Directly provide
l. Case Management – Directly provide
m. Disease Management – Directly provide
n. Provider Credentialing – Directly provide
o. Enrollment Assistance – Do not provide
p. Member Services (inquiry, ID cards) – Directly provide Member Services/ID cards provided through a subcontractor
q. Member Grievances/Appeals – Directly provided

8. Medicaid Program Experience – Population

Using the list below, please submit a chart that includes for each of the states where you currently contract: 1) the population(s) served; and 2) the approximate number of individuals served in each population.

TennCare

- **Aged, Blind and Disabled – excluding dual eligibles – 9,320**
- **Dual Eligibles: individuals eligible for both Medicaid and Medicare – 16,638**
- **TANF and TANF-Related – 53,544**
- **SCHIP - 1,999**
- **Waiver Expansion Population (low-income uninsured) – 2,303**
- **SPMI (Seriously and Persistently Mentally Ill) – unavailable for JDH to break out**
- **SED (Seriously Emotionally Disturbed Children/Youth) – unavailable for JDH to break out**

Iowa

- **SCHIP - 7,800 members**

9. Medicaid Program Experience – Payment Methodology

Please submit a chart that indicates the payment methodology for each state contract, specifically addressing the risk methodology, e.g., full-risk, partial

risk, shared risk, etc. Please also describe any financial incentives you currently participate in, including the applicable service(s) and the measures.

We are currently operating in a shared risk arrangement for TennCare. A summary of the shared risk arrangement is below.

	Admin Risk	Admin Reward
Medical Fund	(2%)	5%
Generic Rx	(2%)	2%
NCQA	(2%)	0%
EPSDT	(2%)	2%
Admits/1000	(1%)	4%
Non ER Use of ER	(1%)	2%
	(10%)	15%

10. Experience – Former Medicaid and/or Commercial

If you currently do not contract to provide Medicaid program services, but have in the past, please provide a brief description of the services you provided and the populations you served. Please also indicate the dates of your previous Medicaid contract(s), and indicate the state you contracted with to provide Medicaid services. If you have never contracted to provide Medicaid services, please provide a brief description of the services you provide and the populations/markets you serve.

John Deere Health contracted with the State of Iowa from 1986-2004 for their Medicaid program. The contract included all medical services excluding drugs, dental and mental health/substance abuse.

11. Reformed Managed Care Model

As part of its reform efforts, the State of Tennessee intends to return to a capitated managed care delivery system. The State is interested in contracting with experienced plans that are capable of coordinating services across the full continuum of care – from preventive and primary care services to long-term care services, as well as across physical and behavioral health conditions. The MCO benefit package will include behavioral health services, but long-term care services and pharmacy services will continue to be carved-out. As part of this emphasis on management and coordination of care the State intends to include a strengthened disease management strategy

designed to manage high cost conditions and to manage care across the continuum of service.

A. Behavioral Health

Unlike the current program, the State intends to coordinate behavioral and physical health services through the MCO relationship in order to improve coordination of care. This decision results from (a) the State's previous experience with disputes between the MCO and BHO regarding the responsibilities of each entity for particular patients or diagnoses and (b) the high proportion of behavioral health products and services provided by general and family practitioners and pediatricians, currently beyond the reach of the BHO's expertise. The State also seeks to expand its options relative to the likely bidding pool in order to ensure participation of the broadest array of experienced candidates. Thus, both single-entity, "pureplay" BHOs and MCOs, as well as integrated health plans may participate; however, the MCO would be expected to be the primary contractor and to fully manage and coordinate an enrollee's physical health and behavioral health conditions.

1. Is your organization currently responsible for providing behavioral health services? If yes, in what state Medicaid programs? Please describe the services you provide and to what populations. Please specify if you serve individuals with serious emotional disturbance (SED) and/or individuals with severe persistent mental illness (SPMI). Please also specify whether you provide these services directly or whether you use a subcontract arrangement. If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured. How/who handles member/provider services, appeals, claims, etc. How is the subcontractor paid?

Yes, John Deere Health is currently responsible for providing behavioral health services to commercial and Medicare populations. JDH's behavioral health services are provided by a subcontract arrangement. JDH is not responsible for providing behavioral health services to any state Medicaid programs, however our current contracted Managed Behavioral Health Organization (MBHO), United Behavioral Health, does provide services to Medicaid members in other markets. Behavioral health services are provided to individuals with SPMI and SED as medically necessary and within the available MHSA benefits.

Regarding coordination of medical and behavioral health services, JDH maintains a delegation agreement with an NCQA accredited MBHO to manage the behavioral health benefits of members. A mutually agreed upon memorandum of understanding describes the responsibilities of the organization and the delegated entity to carry out to provide behavioral health care to members. The memorandum describes the reporting

requirements for oversight, and the process for handling member/provider services, appeals, claims, etc. Member services are handled when ever possible at the first contact regardless if the call is received by the health plan or the MBHO. Complaints are categorized, tracked and trended on a quarterly basis. Provider services are handled by the MBHO as they maintain contracts for the provider network. Member first level appeals are handled by the MBHO. Claims are processed and paid by the health plan. The MBHO is paid by JDH on a capitated arrangement.

2. Please describe your medical management model for care coordination and service integration between behavioral health providers and physical health providers, in particular an individual's primary care provider. Please describe your experience with ethnically and racially diverse populations in physical health and behavioral health settings.

John Deere Health maintains a coordination of care policy to provide a process in which JDH collaborates with the Managed Behavioral Health Organization (MBHO) to coordinate medical and behavioral health care for members. JDH will collaborate, as appropriate, between medical and behavioral health care with MBHOs that provide behavioral health benefits to our members by means of:
- exchange of information between medical and behavioral health providers;
- appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care;
- appropriate uses of psychopharmalogical medications;
- screening and managing members with co-existing medical and behavioral conditions; and
- cooperate with the MBHO in the implementation of their primary or secondary prevention programs for behavioral health

A population analysis for our membership is completed on an annual basis using demographic information. U.S. Census Data is used and the data shows the most frequently occurring Nationality / Ethnicity and Linguistic needs in the areas served. Using this data UBH completes an analysis of network adequacy and makes any network additions necessary to serve its population.

In addition the MBHO maintains a provider data base that matches the network clinician with a member who may have a specific request. Providers can be identified based on gender, ethnicity, linguistics, and specialty. The MBHO will make accommodations in authorizing services to meet special needs if the provider network does not have an available contracted provider to meet a specific need.

3. While the state believes that the proposed coordinated approach will improve continuity of care broadly, TennCare is particularly concerned

with maintaining the highest quality of care for those individuals on our program with SED and SPMI.

a) Please describe your experience with these populations, including specific programs and interventions (e.g., early intervention, psychiatric rehabilitation and recovery).

The Managed Behavioral Health Organization (MBHO) recognizes the special needs of the SPMI and SED population and the barriers that may prevent a successful treatment outcome. Every attempt is made to treat this population in the least restrictive level of care, crisis intervention and planning, in home services, therapeutic foster placement, assistance with medication cost, therapeutic school placement, community mental health wrap around services, and community resources are often used to successfully treat this population.

When long term residential or custodial treatment may be required the MBHO clinician works with the member assisting with resources for coverage which may not be available or covered through health plan benefits.

b) What structural or contractual design choices would you recommend to ensure the needs of these populations are met?

SPMI or SED members may benefit from residential or custodial treatment when other treatment options have not been successful. We recommend specific criteria for long term residential treatment if covered.

c) Would your interest level in bidding be positively or negatively impacted if the state were to consider excluding these individuals from this proposal?

This group does utilize a more intense level of services and is not always responsive to traditional MBHO strategies. JDH would be supportive of excluding these individuals from the proposal.

d) Would your response to (c) change if the state were to adopt an alternative, more limited or no-risk arrangement for this population?

We would prefer a no-risk arrangement if SPMI or SED individuals are included in this proposal.

4. Please describe your experience working with essential community providers such as community health clinics and community mental health agencies.

Community mental health agencies are often contracted providers and resources are authorized and recommended as medically necessary to meet the individual needs of a member.

5. Based on your experience coordinating physical and behavioral health services, do you have any specific recommendations regarding the design of the behavioral health proposal for TennCare? More specifically, what financial guarantees, if any, might be necessary to ensure appropriate funding for these critical services?

There are two Addendums in our Managed Behavioral Health Organization (MBHO) contract that relate to included and excluded MBHO services. The included services are within the MBHO expertise and are defined in categories by type of service (ER, IOP, Detox, etc). The excluded services are reflected in detail by Disease Category and ICD-9-CM or DSM-IV codes.

Our current contracted MBHO is fully at risk for our members. There is an expected Benefit Cost Ratio (BCR) associated with this contract which is calculated based on claims cost incurred by the MBHO and revenue (capitation) received by the MBHO for those members. Unless the BCR falls within the target, any increase to the capitation amount is to be negotiated.

B. Pharmacy Services

Pharmacy has been a key driver of expenditure growth in the TennCare program. In an effort to control pharmacy costs, the State carved-out pharmacy and contracted with a pharmacy benefits manager (PBM). The State intends to continue the current PBM contract and the carve-out of pharmacy services. The MCO, in conjunction with the PBM, will support all efforts to manage the pharmacy benefit, including, but not limited to, provider education; identification and monitoring of outlier prescribers and users; and coordination of prescriptions across providers.

1. Please describe your approach to a pharmacy carve-out, including specific information on your approach to pharmacy management and cost containment strategies.

Working in conjunction with the PBM, John Deere Health will expand its multi-faceted provider communication and education strategy making use of printed and web-based materials, direct mail, provider group meetings, and for identified target providers, telephone contacts and/or face-to-face meetings to discuss performance improvement opportunities. Pertinent general information

about generic drugs will be regularly and broadly communicated. In addition, individualized provider prescribing data and reports specific to JDH TennCare enrollees will be prepared and disseminated. Using individual provider prescribing data, JDH personnel will identify a target list of high volume providers whose rates of prescribing of generic drugs fall well below the JDH TennCare mean (and whose rates of prescribing of brand name drugs exceeds the corresponding mean). More intensive communication and education strategies will be directed to these targeted outlier providers.

Printed materials include the bimonthly newsletter publication, *Provider Update* that is mailed to all physicians in our network. A section focusing on TennCare matters is included in each issue of this newsletter. JDH has and will continue to provide at least one article or notice in each issue focusing on the prescribing of generic drugs, TennCare program updates including changes in the Pharmacy Short List, Preferred Drug list, new pharmacy edits, and web addresses to access TennCare resources as well as pertinent phone/fax numbers related to TennCare pharmacy management. Web-based materials are provided for JDH providers at www.johndeerehealth.com/Providers/ where JDH maintains an active link to the health plan's ongoing generic prescribing initiative, "Generic Drugs: the Unadvertised Brand". Providers are able to access an array of useful articles and reference tools. Active links to the TennCare PDL, the Pharmacy Short List, and other pertinent TennCare pharmacy reference lists are maintained on this site as well as links to JDH clinical care guidelines that incorporate the use of generic drugs.

In addition to the outreach and education efforts directed to providers JDH will communicate regularly with JDH TennCare enrollees regarding the value and high quality offered by lower cost generics through the newsletter to enrollees, *HealthTalk*. A special edition of *HealthTalk* is published and mailed directly to JDH TennCare enrollees on a quarterly basis. JDH will include one or more consumer-oriented articles focusing on the value and advantages of generic drugs in at least two issues of *HealthTalk* each year.

2. In a pharmacy carve-out scenario, what "real-time" information would you need to manage the benefit? Please be specific.

Complete paid claims data imported into the John Deere Health data warehouse for provider profiling and retrospective analysis is needed. In addition, read only access to the real time TennCare pharmacy paid claims system is necessary to be able to "drill down" into timely details regarding a specific provider or member pharmacy data.

C. Long-Term Care Services

Long-term care services (nursing facility and services through home and community based waivers) will be carved-out of the MCO benefit package.

However, individuals receiving long-term care services (including the aged, blind and disabled population) will be enrolled in MCOs for their acute and behavioral health services.

1. Please describe your methods and procedures for coordinating acute and long-term care services to reduce gaps in services and prevent duplication of services.

   John Deere Health utilization review nurses managing concurrent inpatient review will work with facility discharge planners when members are discharged from an acute or skilled level of service back to a long term care facility. As appropriate, JDH will refer cases needing additional services or coordination of services to a JDH Intermediate Case Manager to identify and facilitate ongoing care needs.

2. What incentives would you recommend including in the MCO contract to drive home and community-based services as a viable alternative to institutional care?

   Member incentives are often effective in supporting home and community-based services as a viable alternative to institutional care. Today, institutional care funding is separate from MCO payment of covered home services. Institutional expenses can be less costly than covered home health services. Developing a broader and more cost effective home health and community program, whether part of the MCO contract or not, would be important to place incentives over institutional care.

D. EPSDT Incentives

As part of the TennCare Middle Region reform the State is focusing efforts on enhanced EPSDT screening rates and compliance with the periodicity schedule. The State is considering the use of incentives to reward MCOs that achieve specific targets.

1. Please describe your current approach to EPSDT services, including your outreach and education component. In addition, if you currently use physician incentive programs to increase participation in EPSDT please describe these initiatives. Also, please provide us with your recommendations regarding the proposed incentives for MCOs, including appropriate and measurable targets, and meaningful incentives.

   John Deere Health's current approach to EPSDT services includes:

MEMBER

Member Handbook

A member handbook is sent to all new members during the first month of enrollment and the entire TennCare membership annually. This handbook outlines EPSDT guidelines, members rights and responsibilities, benefits, transportation information, customer service information, complaint information and provider information.
www.johndeerehealth.com (Click on TennCare-member handbook)
www.johndeerehealth.com (Click on TennCare-Provider Directory)

Member Newsletter

A member newsletter, *healthTALK* is sent quarterly to all TennCare members. The newsletter addresses various health topics and encourages members to seek preventive care, access the John Deere Health web site or other helpful web sites as well as promote EPSDT services.
www.johndeerehealth.com (Click on *health TALK*)

Reminders Prior to Screening Due Dates

A reminder postcard is sent to all children who will be 2,4,6,9,12,15,18, months of age or 1 month prior to their birthday at ages 2-21. These reminders promote the components of a well exam and encourage them to call their health care provider to schedule an exam. The reminders also give them important telephone numbers and transportation information. These postcards are intended to remind the member or caregiver about these important screenings.

Be Wise immunize postcards are sent to children at 2, 12 and 18 months of age as well as 12 and 13 year olds. These postcards address the immunizations required by those ages and the importance of immunization.

Reminders of Overdue Screening Dates

1. All children under 2 and those 2 to 21 years old that are identified to be behind in EPSDT screening are sent an intervention quarterly such as stickers, a bookmark, a postcard or brochure.

This is an attempt to catch-up on screening and promotes EPSDT services. Children living in poverty are considered "high-risk" and more likely to suffer from acute and chronic ill health, which, if not addressed early, can have long-term health consequences. Intervention with this population is important to begin preventive health screenings for early identification of health problems and to promote appropriate health behaviors.

2. A monthly claims report is produced to identify all children under 21 who are in need of an EPSDT screening exam and this information is formatted onto a CD and sent to individual local health departments. This effort is an attempt to reach those children for EPSDT and immunizations. The health departments make outreach telephone calls to set-up appointments for EPSDT services. This process specifically targets children who have received no services within a year. Additional information on other children who are overdue is also included, to further EPSDT outreach.

Outreach to Pregnant Women

The John Deere Health New Generations Program is a voluntary pregnancy program. All women enrolled in this program are sent immunization and EPSDT materials. EPSDT screening and immunizations are discussed via telephone during the term of pregnancy along with pregnancy self care and general baby care. All TennCare Moms are stratified as high risk and receive monthly follow-up telephone calls. All women enrolled in this program are given assistance with finding a provider and making timely appointments.

Other EPSDT Outreach

Collaborative project: Increasing EPSDT visits (15-20 year olds) This project is a collaborative effort by all the MCOs in Tennessee to increase well-child (EPSDT) screening rates in the 15-20 year population. Findings from an analysis revealed low rates for well care visits ages 15-20 for all participating MCOs and identified room for improvement from the baseline measure. A primary purpose of the collaborative workgroup was to develop a meaningful quality improvement project. The findings point to the importance of recognizing that illness is a primary trigger for scheduling and keeping appointments. All MCOs agreed to the message that well care check-ups could detect "serious problems" before they become "life-threatening" and that well care check-ups could identify things that may be otherwise missed (e.g., screens could detect Attention Deficit Disorder, sexually transmitted diseases, or other conditions that parents cannot visually detect). A teen newsletter is sent to all 15-20 year olds to promote EPSDT screening on a quarterly basis.

<u>PROVIDER</u>

Provider Incentive

John Deere Health strives to assist in increasing EPSDT screening rates among eligible children. An identified barrier to receiving EPSDT screening examination is the tendency of patients only making appointments when the patient is ill. Many times, the illness is not too

severe, and the EPSDT exam could be conducted on the same visit. Industry standards do not allow reimbursement for both services on the same date of service. However, in order to incent our contracted providers to perform EPSDT examinations on the maximum number of possible occasions, JDH does reimburse for both the Evaluation & Management and the Preventative Medicine codes for the same date of service.

Provider Newsletter

A Provider Update is sent to all providers bimonthly in the mail, as well as being available on our website. EPSDT education is included in each Provider Update, as well as other health topics, coding, information, and applicable legislative materials. To view the full newsletters, please access the JDH website at:
http://www.johndeerehealth.com/10Provider/02Newsletters/02Provider_Update/

Provider Website

An interactive provider website is available on line that includes links to the TennCare website, TENNderCARE website, and TNAAP website for TENNderCARE EPSDT education, screening forms, etc. Information regarding member benefits, rights and responsibilities, and available specialty providers, as well as an archive of Provider Updates and an online Provider Office Manual are on the site.
http://www.johndeerehealth.com/10provider/

Provider Office Manual

The office manual contains specific TENNderCARE information, and is available to providers in hard copy and on our provider website.

Care Management Tool

Physicians receive information regarding focused disease management and specific member health status via this tool.

E. Utilization Management/Medical Management (UM/MM)

Essential to controlling the current rate of TennCare expenditure growth is a comprehensive and successful utilization and medical management program. As described above, Tennessee intends to have service limits for various benefits, and the MCO will be responsible for managing care within those limits. The proposal currently before the Federal government would allow the State to implement “hard” benefit limits. The only exceptions would include services on the “short list”, which would not count toward benefit limits and continue to be available to enrollees after benefit limits are hit. However, the State is considering moving toward “soft” benefit limits in the future, where services beyond the benefit limit could be provided as cost-effective alternatives to covered services. The MCO would have the lead role in

deciding whether to provide services over the applicable benefit limits. The State expects that these services would be authorized using a prior authorization process.

1. Please describe any experience you have managing care in a state with benefit limits, including both "hard" and "soft" limits. In particular, please describe any experience you have had implementing prior authorization processes as a mechanism to authorize services in excess of benefit limits. Please describe the prior authorization process you would employ for "soft" limits and the general criteria that would be utilized to evaluate requests.

   John Deere Health has experience in managing benefit plans involving both "hard" and "soft" benefit limits. In JDH's experience, use of hard benefit limits is the most effective and efficient means by which to manage cost and utilization. Use of the benefit plan structure itself provides the most consistent and equitable approach to medical management. Use of "soft" limits is currently used in rare circumstances when it is determined by individual physician review that the medical necessity needs for an individual member exceed the benefit plan limits but that it would be the most prudent and cost effective decision to allow a one-time payment exception.

2. Based on your experience, please provide any recommendations regarding specific UM/MM requirements for the State to consider, particularly the use of "soft" limits.

   Use of "soft" benefit limits is a process that is best used in rare circumstances. Routine use of "soft" limits creates higher administrative costs due to the individual case review required which creates the need for more nurse and physician resources to conduct individual review. Any variation or exception to a benefit or use of an "exception list" is viewed by external reviewers (primarily NCQA) as medically reviewable decisions and no longer considered benefit issues. Any use of exceptions, if they are to be used, should be managed at the claim processing level. Example: reimbursement for lab tests is limited to 10 tests annually. Exception: HgbA1c tests are not counted toward that limit.

F. Disease Management

Physical Health

The State intends to incorporate the principles of disease management into its reformed managed care program and a comprehensive and coordinated approach will be expected of all participating MCOs. At a minimum the

expectation would be that the MCO apply disease management techniques to the following physical health conditions:

- Diabetes mellitus
- Congestive heart failure
- Coronary artery disease
- Asthma
- Chronic-obstructive pulmonary disease
- High-risk obstetrics

Below are highlights to our disease management approach to the listed health conditions:

- **Diabetes mellitus**

  Outreach
  Diabetes-specific newsletters 2x annually.
  Educational packets mailed annually.
  Send a Care Management Tool letter 2x annually if they appear on the physician's report. Encourage physician follow up.
  Send a letter to members with lab results outside target ranges and encourage them to attend diabetes self management classes.
  Offer free formulary glucose meters.

  # of Members **31,000**

  Measured Outcomes
  % of members with A1c testing annually.
  % of members with LDL testing annually.
  % of members with A1c <9.
  % of members with LDL <100.
  % of members with annual testing for nephropathy.
  % of members with annual dilated retinal eye exam.
  % of members with blood pressure <130/80.

- **Congestive heart failure**

  Outreach
  Cardiac-specific newsletters 2x yearly.
  Educational packets mailed annually.
  Send a Care Management Tool letter 2x annually if they appear on the physician's report. Encourage physician follow up.

  # of Members **4,000**

  Measured Outcomes

% of members receiving a prescription for ACE/ARB.
% of members receiving a prescription for beta blockers.

- **Coronary artery disease**

  Outreach
  Identify members monthly who have had an acute MI. Provide education regarding beta blocker use, cholesterol management, and lifestyle modifications.

  # of Members **700**

  Measured Outcomes
  % of members post cardiac event with LDL screening.
  % of members post cardiac event with LDL <100.
  % of members post MI with prescription for beta blocker medication.

- **Asthma**

  Outreach
  Asthma-specific newsletters 2x yearly.
  Educational packets mailed annually.
  Contact members with ER/inpatient admissions monthly. Provide education and encourage physician follow up.
  Contact members over-using beta agonist medications quarterly. Provide education and encourage physician follow up.
  Send a Care Management Tool letter 2x annually if they appear on the physician's report. Encourage physician follow up.

  # of Members **7,000**

  Measured Outcomes
  Appropriate use of inhaled anti-inflammatory medications.
  ER admissions per 1,000.
  Inpatient admissions per 1,000.
  Excess beta agonist use.
  Repeat ER/Inpatient admissions per 1,000.

- **Chronic-obstructive pulmonary disease**

  John Deere Health does not currently offer a program for Chronic-obstructive pulmonary disease.

- **High-risk obstetrics**

  Outreach

Telephonic case management services for pregnant women.
Educational packets mailed.
Telephonic post partum follow up.

# of Members **1,500**

Measured Outcomes
% of women receiving timely prenatal care.
% of women receiving timely postpartum care.
% of participants versus # of deliveries annually.

1. Do you have a formal disease management program? If yes, here is it currently being used, e.g., which State Medicaid programs? Again, if yes, on which conditions does your program focus today?

   John Deere Health does have formal disease management programs currently in place for TennCare members. They include:
   Asthma
   Diabetes
   CAD (Post MI Management – Cholesterol/Beta Blocker)
   Heart Failure (temporarily suspended for TennCare due to missing pharmacy data)
   Pregnancy Management

2. Is the function fully performed within your organization or do you subcontract with another entity? If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured.

   The disease management functions are fully performed within our organization.

3. Please describe your disease management approach, and address each of the above conditions specifically. Include in your description how you identify individuals in need of disease management interventions more broadly (including potential future high-cost utilizers); your outreach and education approach; the number of individuals served; your approach to physician behavior, including the use of clinical guidelines; staff qualifications; your experience and approach to managing within the context of benefit limits; and a description of measurable outcomes resulting from the disease management intervention. Please also describe what additional health conditions you might recommended for targeted intervention techniques (e.g., obesity, pain management)?

   All disease management programs are administered by registered nurses with expertise in the specific program they deliver. All programs are

based on nationally-recognized, evidence-based guidelines adopted by the health plan.

The health plan takes a population-based approach to disease management. Eligible members are prospectively identified and updated by monthly analysis of claims data. Members who do not wish to participate in disease management services may "opt out". HEDIS specifications for member identification are used and modified when applicable. Members must self enroll or be referred by a physician for the pregnancy management program.

Our diabetes program received a Quality Profiles award from NCQA for our efforts in improving diabetes management, specifically for our interaction with providers.

When managing diseases within the context of benefit limits, it is the responsibility of the health plan to inform members of the recommended testing and medications they should be receiving for specific conditions. While recommended services may or may not be covered benefits for specific individuals, the importance of these minimum standards of care is emphasized to offset or prevent complications in the future and to improve quality of life. Members are encouraged to use formulary medications and DME items that are of equivalent efficacy and the most cost effective based on their benefit plans. They are encouraged to call Customer Service for clarification about services covered under their benefit plans.

Physicians are engaged in disease management via several methods.

- **Practicing physicians serve on the Medical Advisory Committee and the Corporate Quality Improvement Committee. Evidence-based guidelines are reviewed by these committees, modified as appropriate, and adopted. The guidelines are distributed to physicians a minimum of annually in the provider newsletters and on the provider web site.**
- **Physicians caring for members with asthma, diabetes and heart failure receive a quarterly report, the Care Management Tool, listing their members who are not on appropriate medications, who have not had recommended screenings, or who have lab results outside target range. This report is mailed to providers and is also available on the secure provider web site.**
- **Physicians caring for asthma members receive notification when their patients are overusing beta agonist medications or have had ER/inpatient admissions for asthma.**
- **Provider and member web sites both contain information about medical management services, including interactive tools and links to valuable resources.**

Behavioral Health

In addition, the following behavioral health conditions are targeted for care management interventions:

- Schizophrenia
- Bipolar disorder
- Major depression
- Co-occurring mental illness/substance abuse

4. Does your care management program include behavioral health conditions? If yes, where is it currently being used?

   The following behavioral health conditions are targeted for care management interventions:

   - **Bipolar disorder**
   - **Major depression**
   - **ADHD**
   - **Co-occurring medical illness**

5. Is the function for behavioral health care management fully performed within your organization or do you subcontract with another entity? If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured.

   John Deere Health subcontracts with United Behavioral Health (UBH), a Managed Behavioral Health Organization (MBHO) to perform behavioral health care management. The MBHO maintains care management programs to specifically address major depression and alcohol abuse and dependence. They use nationally recognized clinical guidelines for disorders to determine preferred practice. Level of care guidelines are used to assist in determination of the appropriate level of care at the correct time. Expectations for coordination of care between all treating providers is expected. This exchange of information is requested and monitored across all treating providers.

   - **UBH expects that there will be communication, collaboration and coordination at all levels of patient care between behavioral health clinicians and/or medical care practitioners. UBH communicates this expectation to clinicians through the UBH Clinician Manual, Clinician Newsletters, and the UBH Clinician website, *ubhonline.***
   - **UBH annually surveys a sample of cases, with the member's consent, to determine the rate at which clinicians are communicating with a member's primary or referring physician about the treatment being provided. The results of each survey are reported to the Clinical Policy and Standards Committee and the Quality Improvement Council on an annual basis at minimum.**

- **Care Management Centers (CMC) promote the appropriate diagnosis, treatment and referral of behavioral health disorders through regionally specific mechanisms. These mechanisms may include the following:**

    - **The development of specific articles related to behavioral health, written for Primary Physicians, with the intention of helping them appropriately diagnose, treat and refer members for possible behavioral health issues, such as depression and substance abuse. Some of these articles also may inform Primary Physicians about the appropriate use of psychotropic medications.**
    - **The offering of educational training sessions for Primary Physicians in order to educate and train them in the diagnosis and treatment of frequently seen behavioral health disorders. These educational sessions may be facilitated by UBH physicians or contracted psychiatrists.**
    - **Each CMC collects data to monitor collaboration between behavioral health and medical care, as appropriate.**
    - **In some CMCs the Medical Director may provide input into a Health Plan's Pharmacy and Therapeutics Committee regarding additions or deletions to their current formulary.**
    - **UBH members admitted for acute inpatient behavioral health treatment services receive discharge follow-up and, as appropriate, are enrolled in the Inpatient Follow-up Program. This program monitors continuity of care by contacting members and outpatient clinicians telephonically at regular intervals for at least two months following the member's discharge from facility-based treatment.**

6. Please describe your care management approach to behavioral health conditions, addressing each of the above conditions specifically. Include in your description how you identify individuals in need of disease management interventions; your outreach and education approach; approach to co-morbid mental and physical conditions; the number of individuals served; your approach to provider behavior, including the use of clinical guidelines; staff qualifications; your experience and approach to managing within benefit limits; and a description of measurable outcomes resulting from the management intervention.

BIPOLAR DISORDER

Bipolar disorder is a severe and persistent mental illness that affects over 2 million adults in the United States, or about 1.7% of the adult population in any given year (Narrow, 1998; Hirschfeld, 2003). Due to misdiagnosis, the incidence of bipolar disorders may be even higher than current estimates. According to a survey conducted by the Depression and Bipolar Support Alliance (DBSA), almost 70% of patients were misdiagnosed prior to receiving a diagnosis of a bipolar disorder (Hirschfeld, Lewis & Vornik, 2003).

A UBH population analysis identified bipolar disorder as a top-five diagnosis for adults across all levels of care. Among adult enrollees, bipolar disorder represented 15% of all inpatient services and 6% of outpatient services. The 2004 Population Profile Analysis showed similar results – bipolar disorder was a top-five diagnosis for adults and it represented 16% of inpatient care and 6% of outpatient care.

In November 2003, UBH adopted the APA clinical practice guideline for the treatment of bipolar disorder. Based on the recommendations of this guideline, three monitors related to the effective treatment of bipolar disorder were selected:

- **Adequate medication treatment**
- **Use of psychotherapy**
- **Unplanned inpatient readmissions for patients with bipolar disorder**

DEPRESSION MANAGEMENT

All members hospitalized for depression are enrolled in the United Behavioral Health depression management program. Patients receive welcome home calls, provider follow up with appointment kept verification, and disease education, resources and mailings. Follow up remains in place for 6 month. This is an opt out program and directions to an 800 number for an op out option are provided.

Current 2004-2005 YTD data for John Deere Health members is a 98.6% participation and a 73.5% completion rate.
Rehospitalization rates are also tracked as a measurement of this program success. 2004-2005 30 day rehospitalization rate for JDH is 10%. Target performance is less than 12%.

ADHD

According to the National Institutes of Health NIH Consensus Statement on Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder (ADHD), ADHD is the most frequently diagnosed childhood behavioral disorder, affecting 3-5% of school-aged children (NIH, 1998). At the core of this disorder are symptoms of inappropriate levels of activity and concentration, impulsivity, inattentiveness to tasks, and distractibility. Consequently, there is a strong association between ADHD and poor academic performance, low self-esteem, and conflicts/poor relationships with family, teachers and peers (Klassen, Miller, Raina, Lee, & Olsen, 1999).

UBH has adopted the American Academy of Child and Adolescent Psychiatry's clinical practice guideline for the treatment of ADHD. At least annually UBH monitors one key component of this guideline, the percentage of children diagnosed with ADHD that were prescribed medication by a psychiatrist and received a follow-up medication visit within 45 days of the initial medication visit. This 45 day follow-up recommendation is consistent with the guideline and

recommendations developed by NIH, AACAP, and ICSI; research findings; and other treatment recommendations found in the published literature.

A key measure for this disorder is Completion of Four Ambulatory Visits within Six Months of the Initial Diagnosis and Performance is 42.5%. Quality improvement activities to track and improve this measure are in place.

CO-OCCURING MEDICAL ILLNESS

UBH and JDH recognize the need for coordination of care when co-occurring medical and behavioral health illness are present. The criteria listed below indicate a process for co management of these cases.

Member is identified as meeting one or more of the following criteria:

- **Member is using excessive medical services without improvement.**
- **Member is seeking repeated emergency room services without improvement.**
- **Member is using excessive pharmacy benefits that indicate a concern either due to amounts prescribed or combinations of medications prescribed.**
- **Member requires ongoing mental health and medical intervention in order to stabilize and/or improve in condition or ability to function.**
- **Member's diagnosis requires treatment on a mental health unit but diagnosis is medical in nature.**

JDH Quality Improvement Coordinator and UBH member advocate determine level of coordination needed to meet member need. This may include the following:

- **Notification of member risk requiring UBH Critical Case Management, this provides bi-weekly review of case to prevent re-hospitalization and/or assurance that the member continues to participate in the necessary care.**
- **Request for multi-disciplinary staffing bringing together the primary care physician, UBH treating providers, JDH and UBH Medical Directors, member advocates, and JDH quality improvement coordinator.**

OVERALL EXPERIENCE AND APROACH

UBH provides service to 346,132 total JDH members. UBH is one of the largest behavioral healthcare companies in the country. We serve over 1,700 customers and more than 22 million members nationwide. Ours is a diverse customer base: small businesses, Fortune 100 companies, health plans, universities, public sector entities, each with distinct needs and priorities. In recognition and appreciation of these differences, we operate from nine regional care management centers strategically placed throughout the country, and deliver services through a

nationwide network composed of more than 60,000 professionals and approximately 1,700 facilities.

UBH believes that optimal treatment is attained when delivered in the setting both least restrictive and with the greatest potential for a favorable outcome. Based on more than 20 years of experience, we know it is the efforts of our clinical network that give our members the best opportunity to achieve a level of functioning that does not disrupt their daily life. And so our priority is creating relationships with our network clinicians that ensure appropriate, time-effective clinical treatment. Successful network clinician/UBH partnerships will ultimately create the most positive patient outcomes.

The provider network includes more than 60,000 clinicians representing the highest level of independent practice in each state. We routinely work with psychiatrists, psychologists, psychiatric nurse practitioners, social workers, marriage and family therapists and other licensed masters-level counselors. Our clinicians have a minimum of three (3) years of post-license experience and represent a broad range of areas of expertise, cultural sensitivity and language abilities. Our development philosophy is to work with the highest quality clinicians and programs in a geography and to match their abilities with the needs of our accounts and members in that area. Clinicians who join UBH are available for all our members regardless of benefit design. Our panel also includes an array of facility-based programs to offer intensive levels of services to all UBH members when needed. We believe our clinicians and our hospitals are the keys to our success and we work hard to assure that we maintain a mutually beneficial partnership.

In addition, UBH does not specifically reward clinicians or other individuals for issuing adverse determinations of coverage or service and does not provide financial incentives for UM decision-makers that encourage decisions that result in underutilization.

All MBHO care managers are licensed clinicians with a minimum of 5 yrs experience in behavioral health and/or substance abuse treatment. Care managers make only positive authorization determinations. In circumstances where a care manager cannot make an authorization determination the case is referred to a licensed board certified psychiatrist with the request for an MD peer to peer review of the case. Only MDs make adverse benefit determinations.

In addition, UBH is compliant with the standards and regulations set forth by JCAHO, NCQA, URAC, HIPAA and ERISA. These standards and regulations serve as guidelines to ensure that:

- **Care Management decisions are made within the defined timeframe requirements.**

- **Appropriately qualified behavioral health care professionals are involved in decision-making.**
- **Relevant clinical information is consistently gathered.**
- **Members are informed of the clinical rationale for adverse determinations.**
- **Members are informed of the right to internal and external appeals.**
- **Members are informed of the right to access relevant portions of their medical records.**
- **Members are informed of the right to file suit under ERISA, when applicable.**
- **Member confidentiality is maintained.**
- **State-specific utilization review laws and specific contract requirements are followed when they are more restrictive than this policy.**

UBH recognizes these treatment guidelines Procedure	**Recommended Guideline(s)**
ADULTS:	
Acute Stress Disorder and Posttraumatic Stress Disorder	**American Psychiatric Association**
Bipolar Disorder	**American Psychiatric Association**
Borderline Personality Disorder	**American Psychiatric Association**
Alzheimer's Disease and Other Dementias of Late Life	**American Psychiatric Association**
Eating Disorders	**American Psychiatric Association**
Major Depressive Disorder	**American Psychiatric Association**
Obsessive Compulsive Disorder	***Expert Consensus Guideline Series***
Panic Disorder	**American Psychiatric Association**
Schizophrenia	**American Psychiatric Association**
Suicidal Behaviors	**American Psychiatric Association**
CHILDREN/ADOLESCENTS:	
ADHD	**American Academy of Child & Adolescent Psychiatry**
Anxiety Disorders	**American Academy of Child & Adolescent Psychiatry**
Autism/Other Development Disorders	**American Academy of Child & Adolescent Psychiatry**
Bipolar Disorder	**American Academy of Child & Adolescent Psychiatry**

Conduct Disorder	**American Academy of Child & Adolescent Psychiatry**
Depressive Disorders	**American Academy of Child & Adolescent Psychiatry**
Obsessive Compulsive Disorder	**American Academy of Child & Adolescent Psychiatry**
Substance Use Disorders	**American Academy of Child & Adolescent Psychiatry**
Suicidal Behaviors	**American Academy of Child & Adolescent Psychiatry**

When a member's behavioral health benefits are exhausted, Care Managers are available to help the member obtain continued care through alternative resources. Such resources may include publicly funded agencies or facilities, sliding scale discounts for continuation of outpatient therapy or benefit substitutions that are permitted by the member's Certificate of Coverage or Summary Plan Description.

- **UBH Care Managers monitor the number of days/sessions used to ensure benefit eligibility for services during an episode of care.**
- **In the case of facility-based treatment, as a member's benefits approach exhaustion, the assigned Care Manager reviews the case in supervision or case staffing to identify alternative treatment options that are clinically appropriate for the member. In some cases, the member may be eligible for substitution of benefits.**
- **The assigned Care Manager reviews the case with the facility providing care, and discusses alternative means for the provision of treatment.**
- **In the case of either facility-based or outpatient treatment, when the benefit is exhausted an Exhaustion of Benefits letter is sent to the member, which informs the member of the fact that benefits are exhausted, and which invites the member to contact a UBH Care Manager to review possible alternatives for additional treatment.**
- **The assigned Care Manager is available to discuss with the member alternative means of receiving additional treatment.**

G. Capitation Model

Under the TennCare reformed managed care model the State will be returning to capitated managed care.

1. Please describe your experience operating under a risk contract for Medicaid and any concerns or recommendations associated with this approach.

John Deere Health has participated in the TennCare program from inception operating under business models that ranged from full risk to partial risk.

Additionally, JDH has participated in the State of Iowa Medicaid full risk managed care program from 1986 to 2004. JDH continues to participate in the Iowa SCHIP Program at full risk.

2. Please indicate if a full-risk capitation environment would negatively or positively affect your decision to participate.

Based on past experience with the TennCare program, the MCO has had limited or no control over key insurance variables such as pricing, benefits, eligibility, and various court decrees which imposed variability to cost instrumental in effectively managing full risk business models. Additionally, the ongoing capital requirements to maintain Risk Based Capital levels needed for superior insurance ratings would require the TennCare program to yield rates of returns never achieved by MCOs participating in the program. As such, a full risk capitation environment would likely negatively affect our decision to participate without substantial modification from current program operating parameters which better align responsible stakeholders and risk.

3. The State is committed to a capitated approach for the core benefit package, as described above, for all enrollees. If you prefer an arrangement other than full risk, however, please describe the mechanisms you would prefer, such as:

a. State supported stop loss provisions based on annual per member expenditures (e.g., the state reimburses X% of costs between $X and $X per member per year)
b. If the State adopted "soft" benefit limits, State supported stop loss provisions based on per member benefit utilization (e.g., the state reimburses X% of hospital visits over the 20 day annual limit)
c. If the State adopted "soft" benefit limits, aggregate risk sharing (e.g., the state reimburses X% of costs in excess of X% of capitation payments)
d. Other

As described above, John Deere Health would consider a business model where the level of risk assumed matches the control each stakeholder has in managing such risk. We would consider forms that include aggregate and specific stop-loss, corridor risk arrangements or combinations that are mutually agreed to. A key determinant in accepting an expanded risk business model will be the ability of such a model to self sustain adequate returns over time which supports Risk Based Capital requirements of a Superior rated insurance entity.

4. Does your participation depend upon a minimum number of covered lives? If yes, what is the minimum number?

Yes, our participation would require minimum volume levels. Our volume level would be dependent on the ultimate business model developed and agreed to from #3 above.

H. Data and Systems Capability

Critical to the success of the program is the availability of robust, timely data, including encounter data, for use by the State and MCOs to manage and monitor the program. The State is very interested in MCO capacity to obtain and provide data and reports to the State, and capacity to use data for ongoing program monitoring and quality assurance.

1. Please list and describe data, including encounter data, and reports you have experience producing for external monitoring. Please list those states for whom you provide this information.

John Deere Health has successfully complied with all required reporting per the TennCare Contractor Risk Agreement, as well as numerous ad hoc and on request reports from the State. This reporting includes weekly transmissions of 837 Institutional and Professional files as well as provider files. Current encounter data do not have any critical data errors over 2% (one of the state's benchmarks). JDH has also successfully met the State of Iowa Medicaid and SCHIP reporting requirements.

2. Please describe how and what data you use to monitor, measure, and evaluate your performance, including the performance of your network providers and any subcontractors. Please be as specific as possible.

NETWORK PROVIDERS

John Deere Health monitors all state sanction reports and the Office of Inspector General's List of Excluded Entities on a monthly basis. We review state licensing board actions, member complaints and sanctions issued by JDH during credentialing and recredentialing for all provider types.

We also review compliance with JDH disease management standards for primary care providers. We release a quarterly report on physician performance for asthma, heart failure and asthma. Ad hoc reporting is also available.

HEDIS is used to measure overall health plan performance for applicable measures. At the time of credentialing, reports are created to correlate clinical performance with the credentialing process. If deficiencies are noted, medical record review is conducted and corrective plans are implemented.

John Deere Health's Utilization Management process monitors provider performance through various data and such data allows us to look at elements such as practice patterns, and over/under utilization. We periodically review performance and determine which care areas require a special focus or attention. This is in addition to other provider performance monitoring referenced in the pharmacy and disease management sections.

I. Net Worth and Restricted Deposit Requirements

In addition to the statutory net worth and restricted deposit requirements for HMOs, TennCare MCOs must comply with contractual net worth and restricted deposit requirements. The statutory net worth requirement is made on an annual basis based on historical data (see TCA, Section 56- 32-212). The MCO contract requires that the minimum statutory net worth requirement be recalculated before a significant enrollment expansion occurs. In terms of reserves, statutorily MCOs must maintain a restricted deposit in the amount of $900,000 plus specified amounts of premium revenue in excess of $20 million (see TCA, Section 56-32-212). The MCO contract requires MCOs to maintain a restricted deposit equal to the statutory net worth requirement. This requirement will be revised to clarify that the increased restricted deposit amount shall be calculated based on the MCO's TennCare revenue, unless that amount is less than the restricted deposit required by statute. If the amount calculated using only TennCare revenue is less than the restricted deposit amount required by statute, then the contractually required amount shall be equal to the restricted deposit required by statute.

1. Do you consider the net worth and depositing requirements to be a deterrent to contracting with TennCare? If so, please explain.

Yes, under the current risk arrangement the net worth and depositing requirements are a deterrent to contracting with TennCare. The restricted deposits calculation is already grossed up as it assumes that all TennCare cash receipts are "premiums". As TennCare is similar in funding to a self fund funded arrangement, it is contradictory that the deposit requirement includes TennCare "premiums" as TennCare is essentially responsible for the services provided to the policyholders. Secondly, it is unreasonable to mandate that the deposit requirements be held equal to the net worth requirements as it creates an exorbitant pool of funds with a decreased ability to effectively manage our portfolio of investments. We understand the intent to provide significant default protection to the TennCare program. A more acceptable position would better match depository requirements with the true MCO insurance risk.

J. Implementation Timeframe

The State's anticipated timeframe for the procurement and implementation of the TennCare Middle Region reform calls for bid procurement in January, with

selection of MCOs in April and service delivery beginning in October. MCOs and any subcontractors accepting risk (e.g., BHOs) will have to be appropriately licensed in Tennessee prior to implementation.

1. Does the anticipated timeframe of an April 2006 contract award and an October 2006 implementation date impact your decision whether to participate in the program? If yes, how?

As you are aware each potential bidding MCO will need to build an adequate provider network. JDH believes it will take a minimum of four months to effectively build out such a network. It is our opinion that to build out the network, educate the provider community and be prepared for enrollment by October 2006 is likely not a doable implementation date. We would recommend a date no earlier than January 2007.

2. Do you have suggestions or recommendations regarding the procurement and implementation timeframe? What is your recommended minimal and optimal timeframe between contract award and implementation?

See above.